

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013543

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3833

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis, Mo.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John Hosp.		d. STREET ADDRESS (If outside, give location) 3719 Bates St.	
3. NAME OF DECEASED (Type or print) First Middle Last Carl A Lynch.		4. DATE OF DEATH Month Day Year 4 3 63	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-14-87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY City Employed.	
13a. FATHER'S NAME Patrick Lynch.		13b. MOTHER'S MAIDEN NAME Emma Griffith.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates)		17. INFORMANT Address Elizabeth Lynch. 3719 Bates St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <u>4200</u> DUE TO (c) <u>4200</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>1-4-63</u> to <u>4-3-63</u> and last saw him alive on <u>4-1-63</u> Death occurred at <u>8:00 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (D, free or title) <u>John M. Lane MD</u>		22b. ADDRESS <u>4401 Hampton</u>	
22c. DATE SIGNED <u>4 April 63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-6-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph.</u>	
23d. LOCATION (City, town, or county) <u>Kimswick, Mo.</u>			
24. FUNERAL DIRECTOR <u>Southern Funeral Home.</u> 6322 S. Grand Blvd.		25. DATE RECD. BY LOCAL REG. <u>APR 3 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Paul Smith. M.D.</u>			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

VS 300
Rev. 4/59

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DATE AMENDED

ITEM NO.

Dr. McCain.
4401 Hampton
1.30PM-5PM.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Samuel C. Hill

Licensed Embalmer No. 4347

P. O. Address 6322 So Grand

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.